Appendix 6
HCFA 1500 Claim Form Completion Instructions

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Note: Medicaid providers should always verify recipient eligibility before rendering services.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

> ***Mother/Baby Claims***
> A provider may submit claims for an infant if the infant is 10 days old or less on the date of service (DOS) and the mother of the infant is a Medicaid recipient. To bill for an infant using the mother's Medicaid identification number, enter the following:
> *Element 1a:* Enter the mother's 10-digit Medicaid identification number.
> *Element 2:* Enter the mother's last name followed by "newborn."
> *Element 3:* Enter the *infant's* date of birth.
> *Element 4:* Enter the mother's name followed by "mom" in parentheses.
> *Element 21:* Indicate the secondary or lesser diagnosis code "M11" in fields 2, 3, or 4.

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name

Third-party insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require third-party billing as determined by Wisconsin Medicaid.

- When the recipient has dental ("DEN") insurance only or has no commercial insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan ("HPP"), BlueCross & BlueShield ("BLU"), Wisconsin Physicians Service ("WPS"), TriCare ("CHA"), or some other ("OTH") commercial insurance, and the service

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requires third-party billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three other insurance (OI) explanation codes must be indicated in the first box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code   Description

OI-P   PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.

OI-D   DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the health insurer.

OI-Y   YES, the recipient has health insurance, but it was not billed for reasons including, but not limited to:
- √   The recipient denied coverage or will not cooperate.
- √   The provider knows the service in question is not covered by the carrier.
- √   The recipient's health insurance failed to respond to initial and follow-up claims.
- √   Benefits are not assignable or cannot get assignment.

- When the recipient is a member of a commercial HMO, one of the following must be indicated, *if applicable*:

Code   Description

OI-P   PAID by HMO. The amount paid is indicated on the claim.

OI-H   HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important: The provider may not use OI-H if the commercial HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number

Use the first box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Wisconsin Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Wisconsin Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The non-physician provider's Wisconsin Medicaid file shows he or she is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.

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The following Medicare disclaimer codes can be used when appropriate:

Code   Description

M-1   Medicare benefits exhausted. This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service provided is covered by Medicare Part B but is not payable due to benefits being exhausted.

M-5   Provider is not Medicare certified. This code can be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A but not for the date the service was provided.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

M-6   Recipient not Medicare eligible. This code can be used when Medicare denies payment for services related to chronic renal failure (diagnosis code "585") because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Wisconsin Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

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For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 Noncovered Medicare service. This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For *Medicare Part A* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For *Medicare Part B* (all three criteria must be met):

- The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source

Required for non-emergency services. Enter the referring physician's six-character Universal Provider Identification Number (UPIN). If the UPIN is not available, enter the eight-digit Medicaid provider number or the license number of the referring physician.

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use

If a provider bills an unlisted (or not otherwise specified) procedure code, the provider must describe the procedure. If Element 19 does not provide enough space for the procedure description, or if the provider bills multiple unlisted procedure codes, the provider must attach documentation to the claim describing the procedure(s). In this instance, the provider should indicate "See Attachment" in Element 19. Do not bill unlisted procedure codes through electronic billing. Unlisted procedure codes are required to be submitted through paper claims submission.

Element 20 — Outside Lab?

If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise, this element is not required.

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the general code V72.6 for laboratory exams or the current *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required. Wisconsin Medicaid denies claims without the appropriate ICD-9-CM diagnosis code.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

This field must be left blank. Do *not* enter a Clinical Laboratory Improvement Amendment (CLIA) number in this field.

Element 24A — Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one DOS, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field, and subsequent DOS in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.

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- All procedures have the same type of service (TOS) code.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in Element 24F.)
- The number of services performed on each DOS is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit POS code for each service. Refer to Appendix 5 of this handbook for a list of allowable POS codes for independent laboratories.

Element 24C — Type of Service

Enter the appropriate Medicaid single-digit TOS code for each service. Refer to Appendix 5 of this handbook for a list of allowable TOS codes for independent laboratories.

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character *Current Procedural Terminology* (CPT) code. Claims received without an appropriate procedure code are denied by Wisconsin Medicaid.

Modifiers

Enter the appropriate two-character modifier in the "Modifier" column of Element 24D. Please note that
Wisconsin Medicaid has not adopted all CPT, HCFA Common Procedure Coding System, or Medicare modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the appropriate number of units, time units, qualifying circumstance units, or other services billed for each line item. Always use a decimal (e.g., 2.0 units).

Element 24H — EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if both HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

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Element 24I — EMG

Enter an "E" for each procedure performed as an emergency, regardless of the POS. If the procedure is not an emergency, leave this element blank.

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.

Optional — provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report.

Element 27 — Accept Assignment? (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in Element 29, "OI-P" must be indicated in Element 9.) Do not enter Medicare-paid amounts in this field.

Element 30 — Balance Due

Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the provider's name (exactly as indicated on the Wisconsin Medicaid provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

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